The Poliner Case: the Clinical Story

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Like a deadly virus sheltered within an immune cell, peer review has been infected. Ironically, some, who have sworn to "first do no harm," now use peer review as a weapon of harm–"Doctors Who Hurt Doctors."[1] Disingenuous "concern for patients" is used to conceal malicious motives in a legalized charade where absolute immunity protects those who utter the words "peer review," and where form trumps substance at every level.

Events Leading Up to the Sham Peer Review

The process that unfolded was directed at stopping me from practicing at the hospital by removing my privileges to work there as a cardiologist. I had an interventional practice based on outreach patients for a year. I then opened a solo interventional practice at the hospital.

With the first patient I scheduled in the cardiac catheterization lab, I was informed that my privileges were no longer active and I would not be allowed to treat the patient. After I complained, it was determined that there was no basis for the adverse action against my privileges, and I was allowed to provide treatment to the patient.

I pursued a niche specialty in acute coronary syndromes (ACS), attracted local referrals, and explored starting a cardiology group. Patients with ACS (not all insured) frequently presented to the hospital after hours, and on nights and weekends, which cost the hospital staff overtime. Virtually all of the patients who became the basis for the sham peer review were ACS patients.

The Five Cases

The five cases presented below were the five cases that the hospital presented as "evidence" of an alleged pattern of patient endangerment, and which were used to terminate my practice and characterize me as a "dangerous doctor." These cases, which occurred over several months, had malicious reviews that were not revealed. This was not the normal quality assurance process in which problems are identified and the physician is given an opportunity to respond and explain the care provided. All of the cases actually involved a deficiency on the part of the hospital. The patients would have been harmed had I followed the course of treatment demanded by the critics. Following the fifth case, I was presented with the Hobson's choice of either signing an agreement to stop practicing as an interventional cardiologist, or face immediate summary suspension with loss of all hospital privileges. There was immediate and widespread dissemination of news of this event.

Over the period of a month during which I was not allowed to practice in the cath lab, a large number of additional cases were conjured up so as to justify a summary suspension of my privileges. My repeated demands for external review, as provided in the bylaws, were refused.

1. The Rash

This patient was sent from another state as an emergency, underwent catheterization, was treated, and went home well after a short hospital stay. A rash occurred in the post-catheterization period. The hospital maintained that the procedure should not have been performed because a rash occurred afterward. The rash was associated with the hospital's care. A contact allergy to Betadine, listed in the history and documented in the chart, had not been noted. Also, a different contrast agent had been substituted without notice.

2. Acute MI with Cardiogenic Shock

This patient presented with an acute myocardial infarction and went into cardiogenic shock just before the emergency catheterization. The occluded vessel could not be reopened, and the patient died in cardiogenic shock. The case was reviewed by the normal hospital committee and determined to have met the standard of care. In the secret review obtained by the hospital, the hospital held that I should not have attempted to restore blood flow. Additionally, in my opinion, the hospital fabricated the occurrence of a complication, and when this was shown to be impossible, simply substituted another false assertion at trial.

3. Acute Anterior MI Complicated by Stroke

This elderly patient with a history of hypertension presented with a massive acute anterior MI from total occlusion at the origin of the left anterior descending artery (LAD), which was reopened at emergent catheterization. Because of residual clot, the IIb/IIIa inhibitor, ReoPro, was given, and discontinued the same day. At the time of this case, this was the drug in nationwide use. In the early hours of the next day, the patient began to develop neurologic symptoms. A stat platelet count was done, and as the platelet count was low, an immediate platelet transfusion was ordered by telephone. After consultation with a neurologist, a neurosurgeon, and a hematologist, the patient underwent an operation for a cerebral hemorrhage later that evening. After a protracted stay, with rehabilitation, the patient was discharged.

This case came to the hospital's attention from an incident report filed by the intensive care nursing staff about the cath lab. The post-catheterization orders had not been carried out while the patient was retained in the recovery area for many hours instead of going to the intensive care unit (ICU), and the time of the procedure had not been communicated in nursing report, further delaying the orders.

The secret hospital review report maintained that standard treatment used in preventing blood from clotting with the reopening of the LAD should not have been given. It alleged that

ReoPro must never be given with heparin because "it's dangerous." In fact, heparin is always given with ReoPro during interventions, and it's considered malpractice not to do so. Even knowing in retrospect that the patient had a CNS bleed, the hospital maintained that I should have come to the hospital to order the platelets, instead of ordering them immediately by telephone. The hospital also alleged that I should have operated on the brain immediately, despite the low platelet count, the need to stabilize the patient, and the decision of the neurosurgeon to operate electively in the evening. The hospital, incidentally, took an inordinate amount of time to deliver the emergently needed platelets.

4. The Sheath

This elderly patient presented with an acute subendocardial MI, complex disease, and significant cardiac dysfunction. He underwent staged intervention and was discharged in good condition. This case came to the hospital's attention when the cath lab filed a report about the handling of a sheath (arterial access line) dressing in the ICU. The ICU staff responded in writing.

The discarded sheath had been sent for culture, without an order or indication. The culture was contaminated, according to the infectious disease consultant, and the results were thus irrelevant. The hospital's secret review claimed I had refused to change an infected sheath and had performed a procedure through it. This was impossible because interventions there at that time required a larger catheter and could not be done through the smaller diagnostic sheath. Also, the sheath could not have been cultured without removing it.

Additionally, the hospital alleged that lines placed in the cath lab needed to be removed within hours—an assertion that is not true in any hospital.

5. The LAD: the "Wrong Artery"

This patient presented to the emergency room in the early hours of the morning with chest pain that persisted despite treatment. The cath lab was called but refused to start the case at this early hour. Instead, the patient's procedure was the first of the normal day, causing a complaint about interfering with the schedule. That is why a competing cardiologist came in and watched the case from the control room.

At catheterization, the right coronary artery was found to have multiple extremely severe sites of narrowing. The muscle it supplied was not moving normally, and the electrocardiogram showed changes reflecting a problem in this area of the heart. After a procedure addressing this complex disease, the patient became pain free. I dictated the report immediately after finishing because of the unusual complexity, before reviewing the film.

The film showed that the LAD divided into two limbs that were close together. Right at the point of division, the medial limb was totally closed and couldn't be seen when the LAD was injected with contrast. There was also unusual right coronary anatomy. In this case, there were technical difficulties with the camera, which would not rotate to one side, thus eliminating all the views normally acquired from that projection. The patient was severely claustrophobic and in pain. I concentrated on fixing the emergent problem with the right coronary; from the limited study under difficult circumstances, the vessel seen supplying the front of the heart was consistent with an intact LAD.

On reviewing the film, after I had cared for the patient's complex and urgent difficulties, I noted that a segment of the LAD visualized from the right coronary injection was part of the LAD that was occluded. I dictated an addendum to the report and wrote what happened in the chart.

I accompanied the patient to an expansion ICU, which was opened for him. The telephone in the expansion ICU was not activated to receive incoming calls. After I had left the unit, the staff there allowed him to sit upright with the sheath in place in the right groin, although he had been treated with ReoPro—the national standard in interventions at the time—because of the complex nature of the case. A small hematoma developed in the groin. The nurses ordered an X-ray, and when the tube was placed over him, the patient became agitated because of claustrophobia. They restrained him, and he resisted against the restraint. In the time it took me to return to the unit—prolonged because of the inability to communicate with them−the patient had bled into the muscles of the anterior abdomen, sides, back, and both legs. It took hours for the hospital to get the patient urgent treatment with platelets to reverse the ReoPro.

The patient eventually underwent rehabilitation and was discharged. The hospital falsely claimed in this case that there was an acute MI in the distribution of the closed segment of vessel from the LAD. In fact, that part of the heart muscle had good blood flow from a named collateral channel from the proximal right coronary artery. It was functioning normally, and there were no electrocardiographic abnormalities.

The hospital claimed that "the surgeon operated on the wrong artery." In fact, it is plain that I had opened the *correct* vessel, the one supplying the symptomatic area. There was no need to perform an intervention on an occluded vessel to an area of the heart that had developed ample collateral circulation.

The Hospital Peer Review Hearing

Several months after the hospital banned me from the cardiac cath lab, a peer review hearing was held. Two experienced attorneys from a major law firm prosecuted the case against me. I had the burden of proof to show that the care I provided was within the standard of care.

The hospital hired an expert witness (the same individual employed in the hearing for another cardiologist who had an action taken against him just a few months before my hearing). In my opinion, the hospital's expert provided testimony that could be best characterized as incomplete, untrue, and untrustworthy. Other hospital witnesses delivered malicious testimony against me under oath.

At the hearing, the patient records demonstrated that all of the allegations that had been made against me were untrue. Multiple independent reviewers presented testimony validating my patient care, including testimony by (a) the dean of a major Texas medical center with nationally recognized expertise in cardiovascular disease, (b) the president of the American Society of Angiography, (c) the president of the International Society of Angiology, (d) a state governor for the American College of Cardiology known for interventional work, (e) a nationally recognized expert in emergent care, (f) those responsible for peer review at an institution internationally known for cardiac care in Texas, who had offered

independent review but were refused by the hospital, (g) the chief of cardiology and the chief of the cath lab at a major university, and (h) an expert in intervention familiar with local standards, among others.

The echocardiograms were reviewed and validated by (a) the president of the society that accredits echocardiography labs, (b) the chairman of the Ethics and Practice Committee of the American Society of Echocardiography, and (c) a former president of the American Society of Echocardiography.

At the conclusion of the hearing, it was found that there was no basis for the action by the hospital. Eight months after the summary suspension, all of my privileges in cardiology were restored.

After the hearing, there was an attempt to institute monitoring of my procedures. This failed. I wrote a letter of complaint to the hospital board about the chief of medicine because of the way the entire process had been handled. The chief of medicine was a full-time employee of the hospital. The hospital attorney threatened me with loss of hospital privileges if I sent the letter. Final administrative resolution did not occur for months, as the hospital appeared to be attempting to delay while the statute of limitations was approaching. I was essentially held "hostage" for about a year.

Right before the statute of limitations was about to run out, additional charges were brought against me in a circumstance where I had no hospital responsibility or contact and no patient-physician relationship. These patient care charges were a total sham, and I was subsequently cleared of any wrongdoing. The lawsuit, *Poliner v. Texas Health Systems et al.,* was filed immediately after that event.

The American College of Cardiology

After I had been subjected to a sham peer review, I notified both the president of the American College of Cardiology (ACC) and the chairman of the ACC ethics committee. The chairman of the ethics committee who was the editor-in-chief of the *Journal of the American College of Cardiology (JACC)* wrote an editorial in *JACC* that reflected his review of the cases that the hospital had presented against me. The title of the editorial was "Clinical Peer Review or Competitive Hatchet Job."[2]

Conclusion

Despite the eventual return of all of my privileges, and after a jury unanimously found that defendants acted "maliciously without justification or privilege,"[3] my reputation was ruined, and my practice was destroyed. The sham peer review was highly effective in eliminating me as a competitor, despite there being nothing wrong with the care I provided. It completely destroyed my referral sources. It is hard to undo a label of "dangerous doctor" once it has been indelibly stamped on the physician victim.

The recent decision of the U.S. Court of Appeals for the Fifth Circuit[4] rendered moot the jury's unanimous finding that defendants were not entitled to immunity. The Fifth Circuit decision will undermine quality of care for all patients, and will make it unsafe for ethical, competent physicians to practice in any hospital in the country. A petition for certiorari has been filed with the United States Supreme Court. However, irrespective of the outcome of the appeal, ethical physicians must not tolerate sham peer review in medicine.

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REFERENCES

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4. *Lawrence R. Poliner, M.D., v. Texas Health Systems, James Knochel, M.D.* 537 F.3d 368 (Fifth Cir. 2008).